Routine Vitamin A Supplementation in Senegal Overview, Challenges and Opportunities

Regional VAS symposium

Dakar, April 2016

Plan

- Objectives of the presentation
- Context
- VAS integration within existing childhood care packages
- Approach
- Districts enrolment toward routine
- Implementation process
- Opportunities and threats
- Main results
- Challenges
- Lessons learned & recommendations

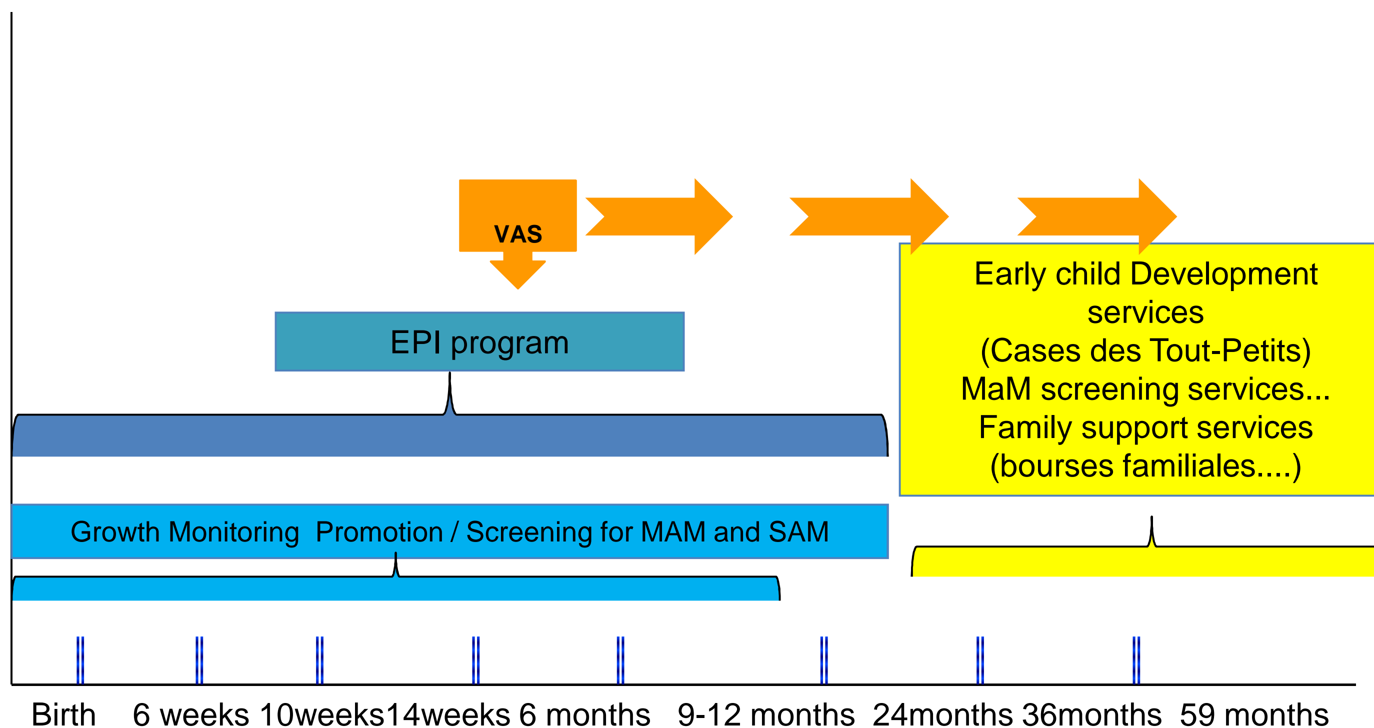
Objectives of the presentation

- Share last 15 years Senegalese VAS implementation context
- Discuss integration initiatives of VAS provision through PHC contacts
- Gather suggestions and contributions to improve the approach

Context

1997	1999 - 2002		2003 -2004		2005 - 2012	2013 +
~ 60% coverage	➢80% coverage		40% coverage		>95% coverage	
MICAH 3 Districts	VAS: NIDS / JLM	NIDs stop	MoH shift to routine VAS	NIDs resume	JLS /NIDS/CHDs	Wave like (campaign/routine)

VAS integrating within existing childhood care packages



Approach

- Support the country move gradually from campaigns toward VAS via routine PHC contacts at the community and health facilities levels.

- Criteria for transitioning
  - Willingness of DHMTs to transit to routine VAS
  - Last 3 CSDs coverage > 80%
  - EPI coverage (Penta 3) > 50%
  - Good network of CHWs and CBOs implementing health community based-activities

- The idea is to have two delivery mechanisms
  - EPI, GMP and screening of acute malnutrition sessions, CHWS home visits used as platforms for routine VAS delivery.
  - VAS campaign will continue to be carried out in no enrolled districts.

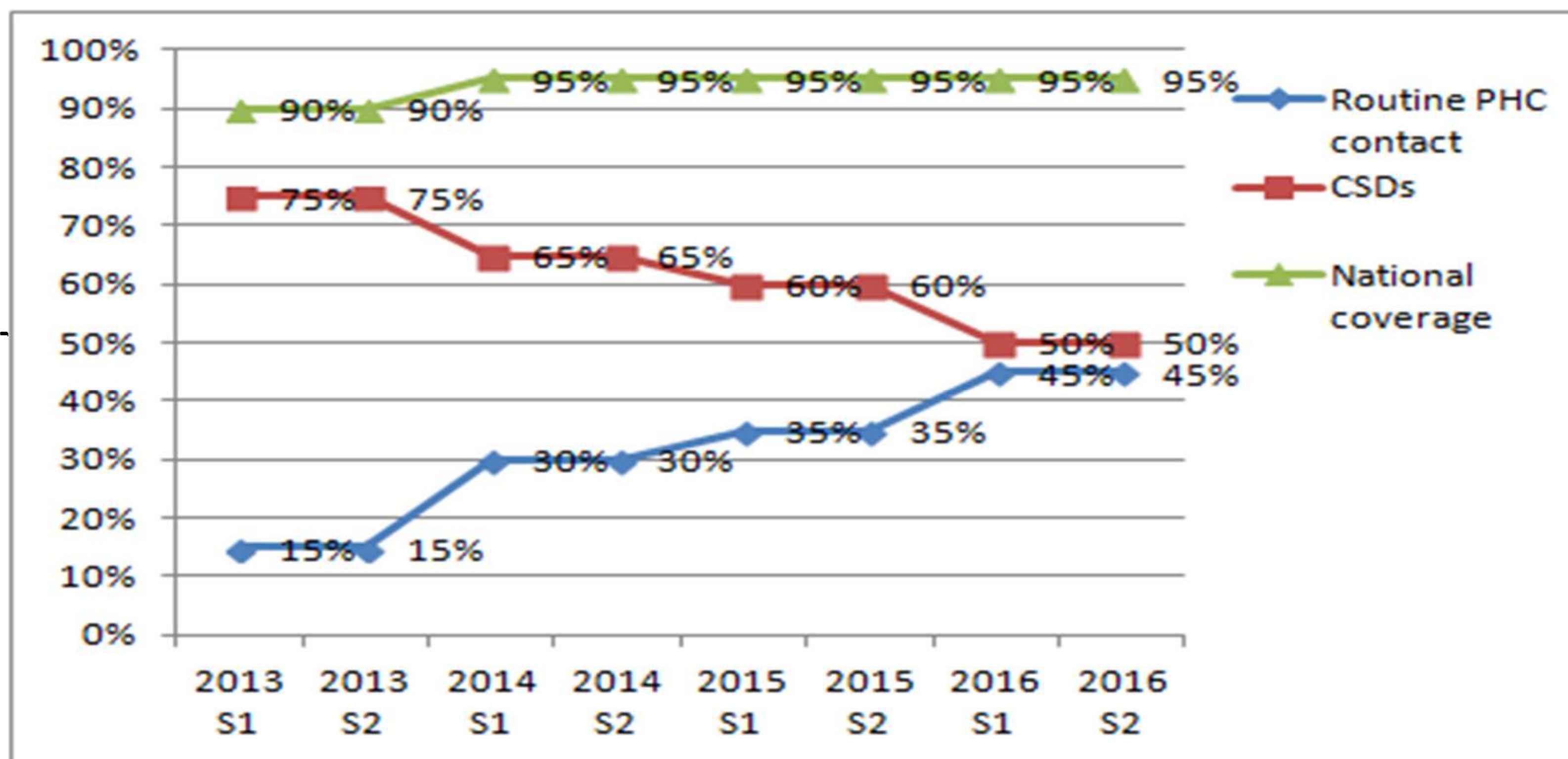
- Purpose: Routine VAS ultimately generalized

District enrolment toward routine

MoH leadreship /Gradual

Inception : June 2013

2013 – 2015: 31 with MI support in 5 regions



2015 -2016 : 16 districts enrolled with UNICEF and HKI support in 4 regions

Implementation Process

- Development of the national plan
- Development of routine VAS Planning, implementing and monitoring guidelines and tools
- Revision of HMIS collection and reporting tools to incorporate VAS
- Gradual development of integrated micro-plans by DMTs from 3 to 31 districts between June 2013 to June 2015
- Training of RMTs and DMTs (trainers), FLHWS and CHWs
- Post – training follow up
- Regional reviews meetings

GAVA partners review

- Routine VAS landscape analysis were carried out

- An action plan focusing on the need for strengthening quality of community based activities developed.

- Commitment of GAVA partners to support routine VAS scaling up process

- Development of a community-based routine VAS monitoring strategy and tools
- Training of PSCC 2 Program Officers and facilitators
- Formative supervision of CHWs in MI targeted regions
- Field supervision
- Routine VAS scaling up process supported by GAVA partners under MoH leadership

Opportunities and threats

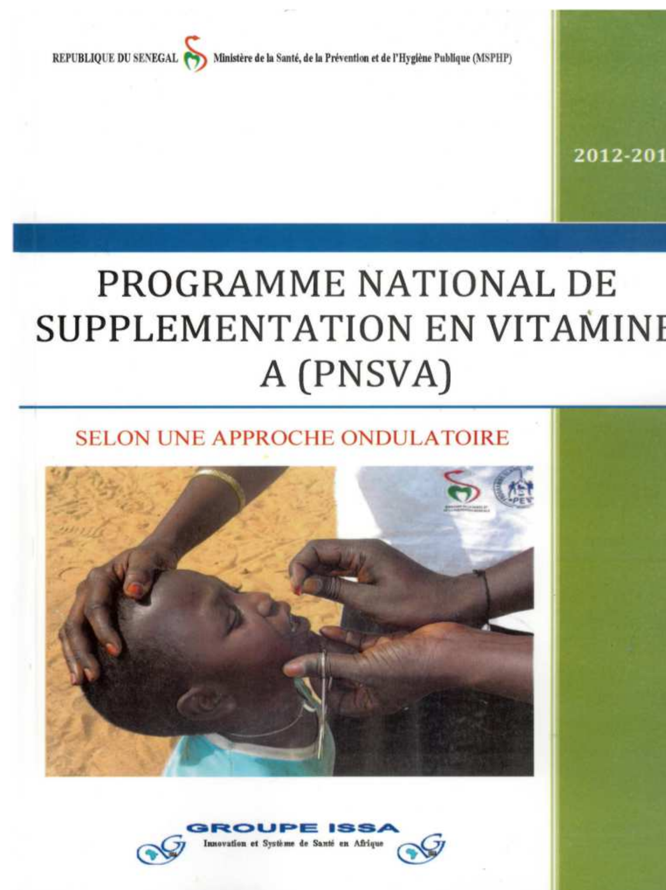
- SVA is a key intervention in national policy documents for child survival
- EPI (well mastered strategies, protocols and tools and strong accountability at district and regional level)
- Platform for community-based nutrition interventions (PRN, PSCC2,..)
- VAS coverage included into the Performance Based Financing (PBF) indicators.
- Free care for children under 5 as part of the Universal Medical Coverage national policy
- VAC included into medicines security plan and the MOU DSRSE/PNA

- Insufficient financial resources from funding partners for supporting CHDs in non transitioning districts
- No presence of an effective and functional community-based VACs supply and management system
- Poor integration of community based health information system into the HMIS
- Strike of public health union
- CHWs motivation

Main achievements and results

National level

- National Program
- Protocol to guide routine VAS implementation and monitoring
- VAS indicators incorporated into the HMIS collection and reporting tools and guidelines
- VAS indicator included into CHWS integrated household checklist
- A training manual VACs management in a routine distribution context
- BCC strategy and tools (posters, CHWs job-aids, radio and TV spots developed)



Main achievements and results

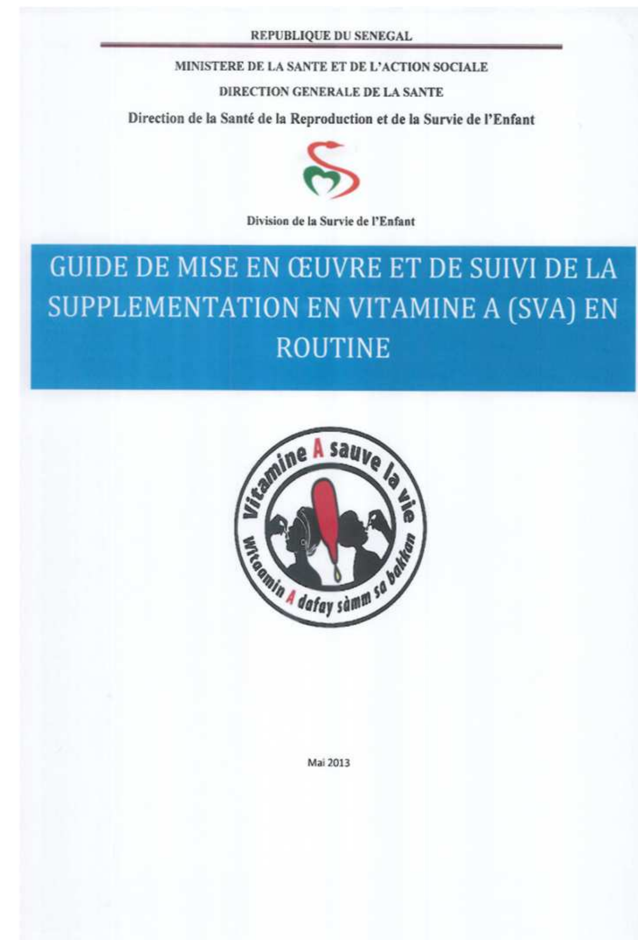
- **Regions and districts level**

  - Integrated routine VAS micro-plans developed and implemented in 47 districts out of 76

  - 1,742 health professionals and 13,994 community health workers trained on routine VAS implementing and monitoring

  - Routine VAS progress (activities and coverage) included into districts monthly coordination meetings and regions quarterly reviews agenda

  - 123 DHTs and drugstore managers trained on VACs supply and distribution management in routine VAS context



REPUBLIQUE DU SENEGAL

MINISTERE DE LA SANTE ET DE L'ACTION SOCIALE

DIRECTION GENERALE DE LA SANTE

Direction de la Santé de la Reproduction et de la Survie de l'Enfant

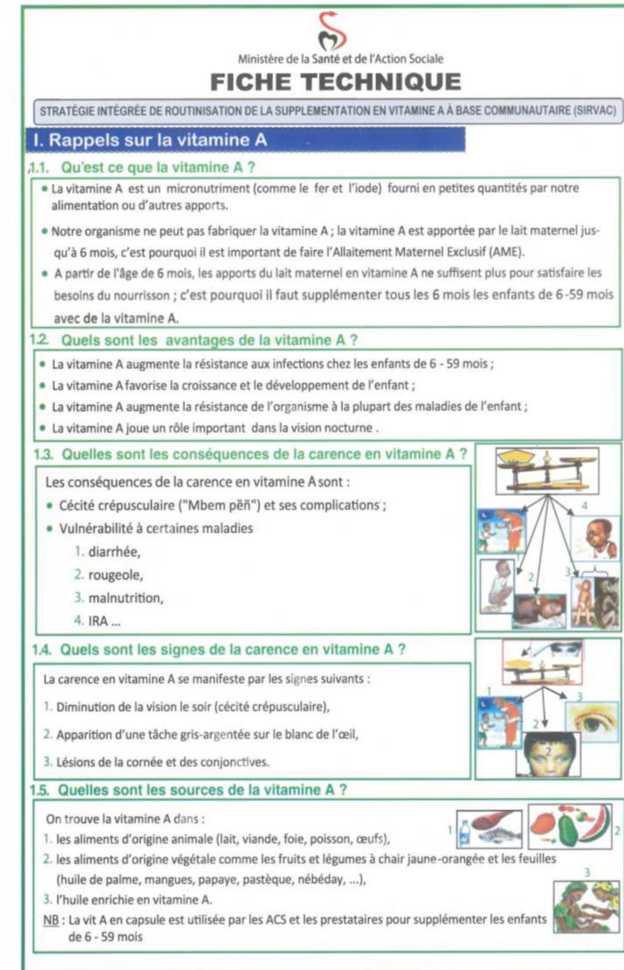
Division de la Survie de l'Enfant

GUIDE DE MISE EN ŒUVRE ET DE SUIVI DE LA SUPPLEMENTATION EN VITAMINE A (SVA) EN ROUTINE

Mai 2013

Main achievements and results

- **Community level**
  - Community-based routine VAS trainer’s manual developed
  - CHWs technical sheet developed
  - 139 PSSC facilitators trained on community-based routine VAS implementation and monitoring
  - Capacity of 3,683 CHWs (1607 health huts and community-based service delivery points) reinforced in routine VAS monitoring and reporting
  - USAID supported the consortium to extend the roll out of the community-based VAS delivery via PHC contacts.



Ministère de la Santé et de l’Action Sociale

FICHE TECHNIQUE

STRATÉGIE INTÉGRÉE DE ROUTINISATION DE LA SUPPLEMENTATION EN VITAMINE A À BASE COMMUNAUTAIRE (SIRVAC)

I. Rappels sur la vitamine A

1.1. Qu’est ce que la vitamine A ?

- La vitamine A est un micronutriment (comme le fer et l’iode) fourni en petites quantités par notre alimentation ou d’autres apports.
- Notre organisme ne peut pas fabriquer la vitamine A ; la vitamine A est apportée par le lait maternel jusqu’à 6 mois, c’est pourquoi il est important de faire l’Allaitement Maternel Exclusif (AME).
- A partir de l'âge de 6 mois, les apports du lait maternel en vitamine A ne suffisent plus pour satisfaire les besoins du nourrisson ; c’est pourquoi il faut supplémenter tous les 6 mois les enfants de 6 -59 mois avec de la vitamine A.

1.2. Quels sont les avantages de la vitamine A ?

- La vitamine A augmente la résistance aux infections chez les enfants de 6 - 59 mois ;
- La vitamine A favorise la croissance et le développement de l’enfant ;
- La vitamine A augmente la résistance de l’organisme à la plupart des maladies de l’enfant ;
- La vitamine A joue un rôle important dans la vision nocturne .

1.3. Quelles sont les conséquences de la carence en vitamine A ?

Les conséquences de la carence en vitamine A sont :

- Cécité crépusculaire ("Mbem pëñ") et ses complications ;
- Vulnérabilité à certaines maladies
  1. diarrhée,
  2. rougeole,
  3. malnutrition,
  4. IRA ...

1.4. Quels sont les signes de la carence en vitamine A ?

La carence en vitamine A se manifeste par les signes suivants :

1. Diminution de la vision le soir (cécité crépusculaire),
2. Apparition d’une tâche gris-argentée sur le blanc de l’œil,
3. Lésions de la cornée et des conjonctives.

1.5. Quelles sont les sources de la vitamine A ?

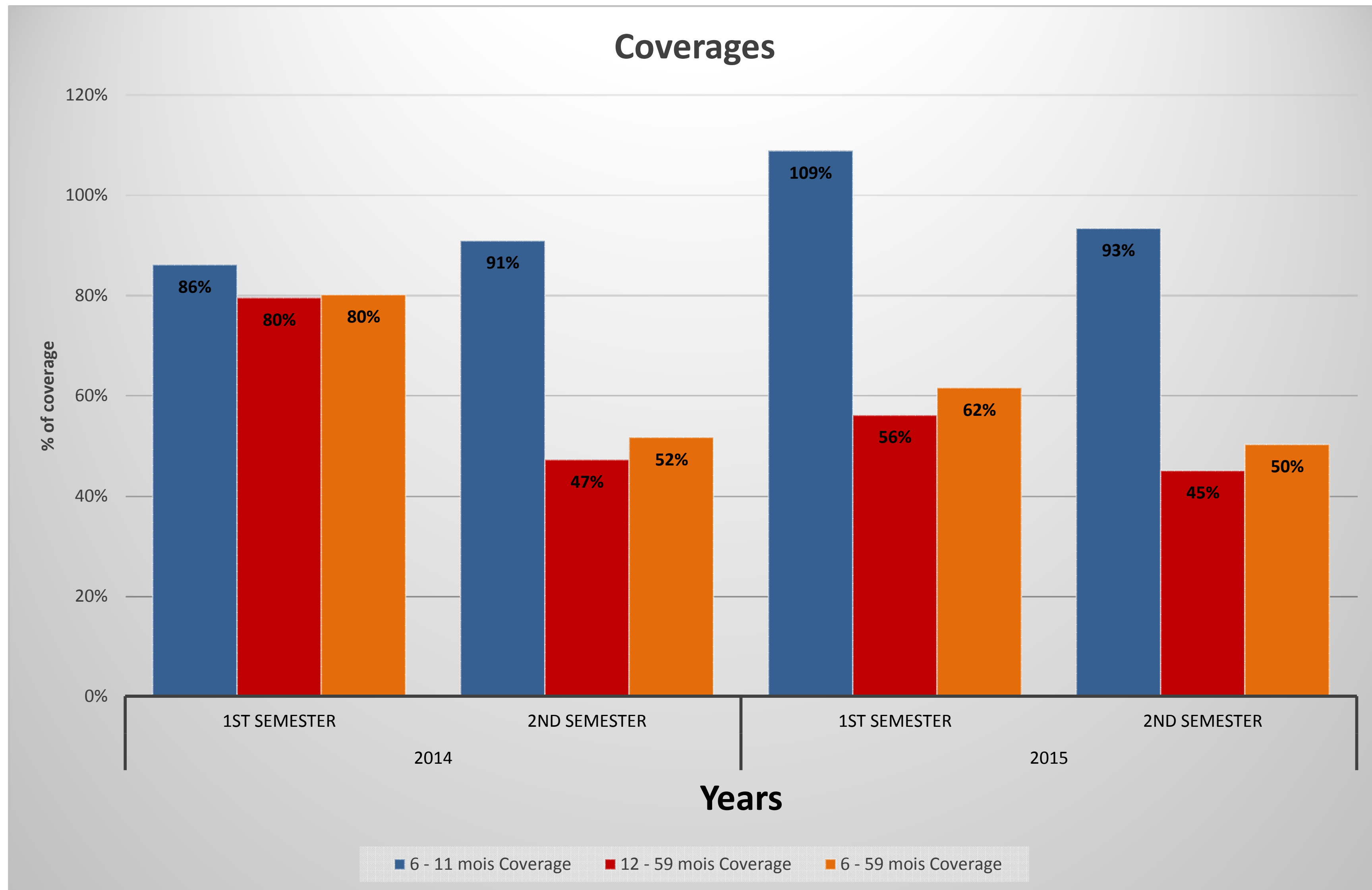
On trouve la vitamine A dans :

1. les aliments d’origine animale (lait, viande, foie, poisson, œufs),
2. les aliments d’origine végétale comme les fruits et légumes à chair jaune-orangée et les feuilles (huile de palme, mangues, papaye, pastèque, nébéday, ...),
3. l’huile enrichie en vitamine A.

NB : La vit A en capsule est utilisée par les ACS et les prestataires pour supplémenter les enfants de 6 - 59 mois

Fiche élaborée et reprographiée avec l’appui du Programme Santé USAID / Santé Communautaire (octobre 2015)

Main achievements and results



Challenges

Low performance of routine VAS coverage for children 12-59 months

Poor coverage reporting of VAS at community level

- VAS delivery not systematically recorded and reported
- Poor supervision of CHWS by Health Post Nurse

Integration in routine PHC platforms not systematic

PHC platforms not systematically used by CHWs to deliver VAS

Poos supervision of CHWs

Low demand for VAS for children 12-59 months

Insufficient BCI for the promotion of VAS demand

Lessons learnt & recommendations

- DHMs commitment and ownership critical to reach high coverages
- Implementation of VAS via routine PHC contacts needs to be conducted with strong field supervision and monitoring
- Reinforcing supportive supervision of CHWs to improve VAS recording and reporting.
- Implementation of the BCI strategy to increase VAS demand through PHC contacts.
- Regular review meetings to timely take corrective actions
- Institutionalization of routine SVA through its systematically integration into health and community services delivery packages

Merci